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Moral Injury – The Lesser-Known Reality for Veterans: A Systematic Review

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Moral Injury – The Lesser-Known Reality for Veterans: A Systematic Review

by

Ryan F. Normandin

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
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Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

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Abstract

This research paper focuses on moral injury, which is a lesser-known psychological problem that veterans face. Veterans face several challenges when they return home from deployment. These challenges are associated generally with combat experiences. Experiences such as roadside bombs, failures of leadership, deaths of fellow service members, the killing of others, friendly fire, and other transgressive acts all contribute to the challenges that veterans face. These experiences can and often do violate our beliefs; our sense of right versus wrong; good versus evil; what it means to be a member of the United States military, etc. These violations can lead to shame, guilt, depression, suicidal ideation, anger, feeling unworthy, loss of meaning, difficulty connecting with loved ones, and feeling unforgivable. In a culture that is dominated by the need for its members to be strong and fearless, it is not surprising why veterans are unable to reconcile their altered reality. All of these feelings contribute to moral injury. They can have a devastating influence on someone's worldview and throw them out of balance. Nevertheless, the most common problem that people hear about is post-traumatic stress disorder. The results showed that there were very few research articles on moral injury when compared to post-traumatic disorder (PTSD) or traumatic brain injury (TBI). This result was found to be the case even though PTSD and moral injury can be co-occurring.

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“Only the dead have seen the end of war.”

-Plato

Introduction

The cost of the war on terror has been well documented over the last 15 years, but it is not the politicians who engage our military in wars that must suffer the never-ending consequences. Service members come into contact with a plethora of harrowing situations, such as losing friends during combat operations, failures in leadership that shake deeply held beliefs, taking on enemy fire, or even having to contend with the most mundane aspects of war. It is the military service member that must bear that burden. President Lincoln famously pledged, “To care for him shall have borne the battle and for his widow and his orphan.” The Veterans Administration (VA) has been making good on that pledge ever since and has adopted this as their mission statement (Veterans Administration, 2016). However, today veterans have been in a constant state of war since 2001, and there have been dire consequences for this population.

“Service members are confronted with numerous moral and ethical challenges in war” (Litz et al., 2009, p. 696). These challenges include managing mental health. Mental health is a significant concern for today’s service members, but PTSD and Traumatic Brain Injury remain the most talked about diagnoses for veterans returning home from combat (Moral Injury Project, 2016). The resulting emphasis and attention given to PTSD and TBI have overshadowed moral injury and may have created a treatment gap for service members. Service gaps can have deleterious effects on service members, which can perpetuate problems if left untreated. Recently, there has been more interest regarding the emotional, spiritual, and psychological wounds that service members face (Drescher et al., 2011). It is incumbent upon

our nation to ensure that everything is done to help alleviate or prevent adverse outcomes related to a moral injury.

According to the Watson Institute at Brown University, since 2001, approximately 2.7 million service members have deployed to the combat theaters of Iraq and Afghanistan. This number continues to rise as tensions increase and the military continues to deploy to these regions. These deployments can subject service members to a plethora of events including shootings, improvised explosive devices, and deaths of comrades (Carlson, Stromwall, & Lietz, 2013). However, there are a number of other potential pitfalls associated with combat deployments. Maguen and Litz (2016) came together to describe the causes of moral injuries:

“In the context of war, moral injuries may stem from direct participation in acts of combat, such as killing or harming others, or indirect acts, such as witnessing death or dying, failing to prevent immoral acts of others, or giving or receiving orders that are perceived as gross moral violations (2). The act may have been carried out by an individual or a group, through a decision made individually or as a response to orders given by leaders.” (p.1)

At their very core, moral injuries “transgress deeply held moral beliefs, or they may experience conflict about the unethical behaviors of others” (Litz et al., 2009, p. 696). Moral injuries are likely to occur following an event associated with betrayal, inappropriate or disproportionate violence, civilian-related events, and within ranks violence (Drescher et al., 2011). The effects of these experiences of combat often have a adverse impact on the service member. This can include social problems, loss of trust or a sense of betrayal, spiritual issues, psychological problems, and self-depreciation (Drescher et al., 2011). However, this information does not explain why almost half of all service members who kill themselves have never

deployed or even left the United States. The idea that so many non-deploying service members kill themselves contradicts a long-held belief by many lay people who believe combat perpetuates the vast majority of suicides among veterans.

What the general public hears about most often is Post Traumatic Disorder (PTSD); however, there is empirical research that moral injury may better describe what returning combat veterans face after their service in the military is complete (Drescher et al., 2011). There is also the possibility that PTSD and moral injury are comorbid. It can be difficult to ascertain the difference between moral injury and PTSD because they share similar symptoms (See Table 1).

The VA released a report that analyzed more than 55 million service records that ranged from 1979 to 2014 (Veterans Administration Report, 2016). According to the report, veterans made up 18 percent U.S. adult suicide-related deaths, which was a reduction from 22% in 2010 (Veterans Administration Report, 2016). Since 2001, suicides in the U.S. adult (civilian) population increased by 23 percent (Veterans Administration Report, 2016). During the same period, veteran suicides rates rose by 32 percent (Veterans Administration Report, 2016). Overall, veterans have a 21% higher likelihood to commit suicide compared to the rest of the U.S. adult population when age and gender is controlled (Veterans Administration Report, 2016). The military and other organizations have pledged to combat this epidemic, but to date, there does not appear to be a “smoking gun” that explains the high rates of suicide among military service members and veterans. Moral injury has recently gained more attention and has the potential to help demystify this epidemic.

The Veterans Administration has provided several examples of a moral injury. They are as follows: Unintentional errors; military personnel are well trained in the rules of engagement and do a remarkable job making life or death decisions in war; however, sometimes

unintentional error leads to the loss of life of non-combatants, setting the stage for a moral injury (Maguen, 2016). A moral injury can also be a person's sense that a right versus wrong is violated (Litz et al., 2009). This contradiction can develop into grief, numbness, or even guilt (Litz et al., 2009). Transgressive acts of others: service members are often morally injured by the transgression of peers and leaders who betray expectations in egregious ways (Maguen, 2016). This sort of trauma can take several different forms including perpetrating or failing to prevent or bearing witness to acts that transgress deeply held moral beliefs and expectations; blaming yourself for something that violated your moral code; someone you trust doing something that went against your moral code. These types of experiences can cause some problems (Maguen, 2016). We need more information on this construct because, "[T]he lasting impact of morally injurious experience in war remains chiefly unaddressed" (Litz et al., 2009). These examples are not exhaustive, as there are numerous situations in which a service member may find himself or herself in that could result in a moral injury.

Conceptual Framework

Most practitioners and the general public are familiar with the construct of posttraumatic stress disorder or Traumatic Brain Injury (TBI), but fewer are aware of the construct of moral injury. Moral injury has the potential to explain aspects of mental health problems veterans face that, for example, PTSD or TBI do not. Although a moral injury is a relatively new construct, it has shown promise and appears to fill gaps that are necessary to help returning combat veterans. The overall question explored in this systematic literature review is as follows: How does moral injury affect the mental health of veterans after they return home from overseas combat deployments? To even begin to answer this question we must first be able to understand what

moral injury is and how it can help inform treatment plans as well as how it is different from other diagnoses, such as PTSD.

Although PTSD is a valid diagnosis in many cases, it is not appropriate for all cases in which combat veterans are involved. Problems result if service members are not properly diagnosed. PTSD is considered a fear-based construct as opposed to moral injury, which is described as a transgression of someone's morals and values (Drescher, Foy, Kelly, Lescher, Schutz & Litz, 2011). Moreover, PTSD is the result of trauma. People who survive a trauma are susceptible to and likely to have adverse reactions. Adverse reactions include feelings of hopelessness, hypervigilance, insomnia, anxiety, self-medication, etc. In contrast, moral injuries are the trauma, not the result. For example, in a combat situation, a leader could order a service member to fire on a civilian population despite general orders not to engage non-combatants. In effect, you are under direct orders to kill the defenseless. After a transgressive act such as this, a person may feel guilt, shame, anxiety, and anger/betrayal (Maguen, 2016). Behavioral symptoms could include: anomie, withdrawal, self-condemnation, self-harming, and self-handicapping behaviors, such as chemical use/abuse (Maguen, 2016; Currier, Drescher, & McCormick, 2015). There are similar similarities between PTSD and moral injuries, as it pertains to presenting behaviors or symptoms; however, they differ in that one is a cause and one is an effect. Nevertheless, there is difficulty in pinpointing a singular event that will cause a moral injury, but that does not mean it is impossible to detect.

Although distinguishable from one another, PTSD and moral injury may be looked at in conjunction with one another as viewed through a more holistic approach to treatment. However, for the purposes of this systematic literature review, the focus will remain on moral injury as a standalone construct, but co-occurring situations should be considered for future research.

Over the last 15 years, combat engagements have been a constant for the life of someone who serves in the United States military. “Although the idea that war can be morally compromising is not new, empirical research about moral injuries is in its infancy, and there are more unanswered questions than definitive answers at this point” (Maguen, 2016, p. 1). However, problems associated with moral injury are identifiable even if their implications are immeasurable. Moral injuries can have a debilitating effect on veterans. It is not uncommon for a returning veteran to find it difficult to connect with their family when they come home. Whether this has to do with adjusting to new roles when they return home after an extended period is a debatable presumption. However, not to be overlooked are the experiences of the service member when they were overseas. Did they encounter something so egregious to their belief system that it morally compromised them? Answers to these questions should be sought; however, those answers must be sought out in an ethical and responsible way.

Literature Review

Background

Our country’s military men and women sacrifice themselves for the greater good of the United States and its citizens. These service members do so of their own volition; however, their sacrifices will sometimes result in a significant impact on their lives. The toll that is levied can be devastating, as it can affect a veterans’ morality, sense of self, and spiritual beliefs. The following literature review focuses on the impact of moral injury has on returning combat veterans.

The initial presumption often held by the narratives seen in movies and the media is that service members suffer from PTSD; however, not all service members encounter fear-based incidents that would warrant such a trauma-based diagnosis. Rather, the emergence of moral

injury appears to fill in gaps that PTSD is unable to explain. Every military service member is situated differently. For example, service members who are married represent approximately 50% of our armed forces (Negrusa & Negrusa, 2014). Single service members may not have the support network necessary to help them work past their moral injury whereas married service members may. Understanding moral dilemmas and transgressions is key to understanding how a moral injury can have an impact on a service member's life and how interventions can help. The more support a service member receives, the better off they will likely be in the long term.

One problem that was prevalent in this researcher's review of the literature was the lack of available research and a uniform definition of moral injury. There were several articles that have similar definitions, but few of these articles contain the exact same language. This likely due to the relative infancy of the subject area. This raises concerns about developing interventions and how to measure them without a commitment to one definition. Nevertheless, the academic community appears to be zeroing in on one definition as moral injury becomes more widely accepted by practitioners, patients, and the general public. PTSD is often spoken about in the same breath as moral injury. In the subsequent paragraphs, a description and definition of each are provided.

Definitions

Moral Injury. There are two "flavors," as Shay (2014) describes it, of moral injury. Shay (2014) defines it as "A betrayal of what is right, by someone who holds legitimate authority (e.g., in the military-a leader), in a high stakes situation." Another definition is, "Perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p. 700). Shay tends to believe that both of these definitions are valid and complement one another. The literature does not point to one specific, official,

definition; however, what both definitions seem to have in common are transgressions of moral beliefs.

Jinkerson (2016) further describes a moral injury as follows:

“Phenomenologically, *moral injury* represents a particular trauma syndrome including psychological, existential, behavioral, and interpersonal issues that emerge following perceived violations of deep moral beliefs by oneself or trusted individuals (i.e., morally injurious experiences). These experiences cause significant moral dissonance, which if unresolved, leads to the development of its core symptoms” (p. 126).

There have been some suggestions in the literature that the definition of moral injury should be such that it can be more easily understood by veterans (Drescher et al., 2011). However, the usefulness of this suggestion needs vetting. Nevertheless, there still appears to be a divide on what the definition should be. Drescher et al. (2011) found that PTSD did not adequately cover the morally injurious conditions of combat, which presents an argument for a separate, but equal, construct. However, they did see a moral injury as being more of a co-occurring problem (Drescher et al., 2011).

Posttraumatic Stress Disorder (PTSD). According to the American Psychiatric Association (2013), the diagnostic criterion identifies the trigger for PTSD as follows:

“Exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual: directly experiences the traumatic event; witnesses the traumatic event in person; learns that the traumatic event occurred to a close family member or close friend (with actual or threatened death being either violent or accidental); or

experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related" (p. 271).

Moreover, PTSD can be a perceived threat (Maguen et al., 2011). A study conducted by Maguen et al. (2011), found that 46% of service members reported at least some sort of danger while deployed. Dangerous encounters, or trauma, are the precursors to PTSD. 46% seems to be a high number given the number of people serving in the military today. Encountering danger, however, is not surprising given the nature of the work performed by the military in combat theaters.

New Construct

The term "moral injury" is a relatively new descriptor for something that veterans of combat/war have experienced for generations. "Throughout history, warriors have been confronted with moral and ethical challenges, and modern unconventional and guerilla wars amplify these challenges" (Litz et al., p. 695, 2009). Even in some of the oldest narratives of war available, show what war can do to those who participate (Nash, Silva, & Litz, 2009). "One of the oldest surviving plays by Sophocles tells the story of the hero Ajax's suicide in disgrace after brutally slaughtering farm animals in a dissociative flashback to the Trojan War" (Nash et al., p. 790, 2009). Other literary accounts have come from Homer (*The Iliad*), Shakespeare (*Henry IV*), and Dickens (*A Tale of Two Cities*) (Friedman, 2015). These narratives are common throughout history and the explanations for such behavior are commonly blamed on the supernatural (Nash et al., 2009). For the most part, this sort of relegation to the supernatural associates problems veterans face during and after war in the category of an occupational hazard and something that

the veteran will have to “suck up.” The problem with this thinking is that the problem is never addressed and the veteran is left in a state of perpetual turmoil.

As time has progressed, the view of veteran problems associated with war has changed. In congruence with the change, treatments have also changed. Sometimes these changes are for the better and sometimes for the worse. At various times moral injuries have been referred to as irritable heart, nostalgia, railway spine, soldier’s heart, combat stress reaction, and even sunstroke (Nash et al., 2009; Friedman, 2015). In World War I, moral injuries were referred to as shell shock resulting from a physical disruption of the brain (Nash et al., 2009; Friedman, 2015). In 1916, a nonmedical model was chosen to explain the symptomology going forward (Nash et al., 2009). The result of this shift had consequences. Service members were far less likely to come forward to seek help (Nash et al., 2009). The view that it was more of a physical problem deserving of medical intervention became popular even though there was no dispositive evidence of a brain injury (Nash et al., 2009). “Hysteria” became the new descriptor and was apparently meant to be a label that would negatively stigmatize war veterans (Nash et al., 2009). This stigmatization would pervert the ranks of military service members for years to come and its effects are still felt by today’s generation of service members.

It was not until 1980 that the DSM-III ushered in a new understanding and contained the new diagnostic entity, PTSD (Nash et al., 2009; Friedman, 2015). At the time, it referred to PTSD as “a normal reaction to an abnormal event” (Nash et al., 2009). This change was the result of research that dealt with Vietnam War Veterans, Holocaust survivors, sexual trauma victims, among others (Friedman, 2015). “The DSM-III criteria for PTSD were revised in DSM-III-R (1987), DSM-IV (1994), DSM-IV-TR (2000), and DSM-5 (2013) to reflect continuing research. One important finding, which was not clear at first, is that PTSD is relatively common.

Recent data shows about 4 of every 100 American men (or 4%) and ten out every 100 American women (or 10%) will be diagnosed with PTSD in their lifetime” (Friedman, 2015). Despite this progress in understanding trauma in veterans, there remains more room for better understanding. The years of negative stigmatization remain, even today, and service members still have a difficult time coming forward when they are having problems. Nevertheless, a change in direction away from the medical model was a welcomed change. Unfortunately, a moral injury does not yet have a defined position, like PTSD, in the effort to serve veterans when they come back from the battlefield. PTSD and moral injury may be co-occurring, but more research is needed to determine if this is the case. For now, looking at each construct, separately, will help researchers better understand subtle differences. It is enough now to know that some symptoms do overlap.

Most service members are unfamiliar with moral injury and the general public knows even less. Research in this area has mainly been in the form of “working conceptual models” (Litz et al., 2009; See Figure 1). Put another way, the research has been theoretical with little to no measurement tools. The Veterans Administration (VA) is the largest and most expansive resource available to veterans, but even the VA focuses more on PTSD and has even established a Nation Center for PTSD. Well-suited interventions for PTSD are what is used to treat veterans, but it does not necessarily capture everything the veteran is facing. The reality right now is that the Veterans Administration will utilize only empirically based psychotherapies (EPBs) (Finlay, 2015). Current interventions for PTSD, such as cognitive therapy, have proven to be inadequate for the treatment of moral injury despite best intentions (Litz et al., 2009; Drescher et al., 2011). There is some resistance by practitioners to embrace moral injury because of the lack of

empirical research and difficulty in pinpointing specific incidences that would cause a moral injury. This lack of empirical research further exacerbate problems related to moral injury.

Since moral injury is in its infancy as a construct, Litz et al. (2009) propose the modified CBT as a way of addressing moral injury:

“(1) A strong working alliance and trusting and caring relationship; (2) preparation and education about moral injury and its impact, as well as a collaborative plan for promoting change; (3) a hot-cognitive, exposure-based processing (emotion-focused disclosure) of events surrounding the moral injury; (4) a subsequent careful, directive, and formative examination of the implication of the experience for the person in terms of key self-and other schemas; (5) an imaginal dialogue with a benevolent moral authority (e.g., parent, grandparent, coach, clergy) about what happened and how it impacts the patient now and their plans for the future or a fellow service member who feels unredeemable about something they did (or failed to do) and how it impacts his or her current and future plans; (6) fostering reparation and self-forgiveness; (7) fostering reconnection with various communities (e.g. faith, family); and (8) an assessment of goals and values moving forward” (p. 702).

Social Workers have a responsibility to utilize the best possible practice model when working with clients. Most often, social workers utilize an evidence-based treatment (EBT), such as cognitive therapy noted earlier. The Code of Ethics does not plainly state that this is mandated; however, a review of the Code of Ethics would seem to mandate it. For example, the Code of Ethics has a value of “competence” with an ethical principle stated as follows: “Social workers practice within their competence and develop and enhance their professional expertise” (NASW, 2008). The principle is further explained, “Social workers continually strive to increase

their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession” (NASW, 2008). This value and principle contribute to the idea that not only should a social worker practice competently, but also a social worker must do their best to improve practices and innovate where possible. For the purpose of moral injuries, the current treatment models do not appear to fully encapsulate a best practice for treatment, which is why more research is needed to explore alternatives to today’s EBTs or modify them to as Litz et al. (2009) did with CBT.

As it stands now, one of the most common therapies utilized at the VA is Cognitive Processing Therapy (CPT), which is an EBT (Finlay, 2015). The problem with this therapy, when utilized for moral injury, is that it tends to devalue feelings of guilt and denies the factual basis of guilt (Finlay, 2015). This is problematic because guilt is one of the most significant emotions felt when someone faces a moral injury (Litz et al., 2009). “[EBTs] were primarily developed to target life-threat or danger-based posttraumatic memories and beliefs among victims of trauma” (Maguen & Litz, 2016, p. 3). Moral injury does not necessarily fall into the category of life-threat or danger-based. Proper therapies are required to treat any condition; moral injury is not different from any other condition in that regard. CPT is just one example of an EBT, as there are several more that are utilized by organizations, such as the VA, to treat veterans.

Additional treatments offered by the VA are Prolonged Exposure Therapy, Medications, Stress Inoculation Training, Eye Movement Desensitization and Reprocessing (EMDR), and Disaster Mental Health Treatment (National Center for PTSD, 2016). The VA identifies these treatments as basics, but they focus on PTSD, not moral injury. There does appear to be some

literature indicating that moral injury can benefit from these treatments; however, the extent that they are effective is still not yet known.

Symptoms

Roughly 10-20% of the two million troops who have served in Afghanistan and Iraq have developed a mental health problem (Gray et al., 2012). A transgressive act can be used to pinpoint experiences that result in a violation of acceptable conduct (Frankfurt, 2016).

“Transgressive acts can be directly experienced, witnessed, or learned about” (Frankfurt & Frazier, 2016, p. 2). For example, a transgressive act could come in the form of an unintentional error, such as firing at insurgents in a combat situation and accidentally killing a non-combatant child. The problem with identifying transgressive acts for moral injury is that it is thus far inconclusive as to what “acts” are transgressive (Frankfurt, 2016). These acts can come in many forms and vary in perceived intensity by the individual.

“Military personnel returning from modern deployments are at risk of adverse mental health conditions and related psychosocial functioning related to killing in war” (Maguen et al., 2010). It is not uncommon for individuals to repeatedly contradict their consciences (Frankfurt, 2016). However, the degree of those contradictions is usually not severe enough to cause a moral injury. The following excerpt from Wood’s (2016) article providing an overview one Marine’s experience in Afghanistan:

“[Nick Rudolph] was sent to war as a 22-year-old Marine and in a desperate gun battle outside Marjah, Afghanistan, found himself killing an Afghan boy[.] [W]hen Nick came home, strangers thanked him for his service and politicians lauded him as a hero[.] [Imagine] that awful day in the summer of 2010, in the hot firefight that went on for nine hours. Men frenzied with exhaustion and reckless exuberance, eyes and throats burning

from dust and smoke, in a battle that erupted after Taliban insurgents castrated a young boy in the village, knowing his family would summon nearby Marines for help and the Marines would come, walking right into a deadly ambush. Here's Nick, pausing in a lull. He spots somebody darting around the corner of an adobe wall, firing assault rifle shots at him and his Marines. Nick raises his M-4 carbine. He sees the shooter is a child, maybe 13. With only a split second to decide, he squeezes the trigger and ends the boy's life. The body hits the ground. Now what? Nick explains, "We just collected up that weapon and kept moving." Going from compound to compound, trying to find [the insurgents]. Eventually they hopped in a car and drove off into the desert" (p.1)

Nick's story is not uncommon. There are some service members who have faced similar situations and some that have not experienced something quite as dramatic or dangerous. Nevertheless, these experiences can lead to symptoms of a larger problem that must be contended with to prevent it from exacerbating further. There are several symptoms of moral injury, which have been found to be very broad (Jinkerson, 2016). Drescher et al. (2011) found that symptoms could include social problems, loss of trust or a sense of betrayal, spiritual problems, psychological issues, and the potential for self-depreciation. It is not uncommon for a sort of spiritual crisis to be described with veterans of combat (Litz et al., 2009; Shay, 2003). However, some symptoms prevalent in a PTSD diagnosis are also prevalent in a moral injury with certain distinctions (See Figure 1).

There are overlapping components of PTSD and moral injury, but there are also distinct differences (See Table 1). PTSD has a triggering event of an actual or threatened death or serious injury (Litz et al., 2009). For example, PTSD is characterized by a "startle" reflex, memory loss, fear, and flashbacks (Wood, D., 2014). In contrast, a moral injury is an act that violates deeply

held moral values (Litz et al., 2009). For example, sorrow, grief, regret shame, and alienation are all associated with moral injury (Wood, 2014). The individual's role at the time of the triggering event is also a factor, whether the individual is the perpetrator or victim. Symptoms typical of both PTSD and moral injury include, but are not limited to, anger, depression, anxiety, insomnia, nightmares, and self-medication with alcohol or drugs (Wood, 2014). The distinction is apparent with PTSD being a fear-based, singular event and moral injury being more analogous to taking part in a morally ambiguous set of combat events (Wood, 2014; Gray et al., 2012).

Moral Injury Assessment

MIQ-M. As moral injury is an emerging construct, a need for a new instrumentation has developed (Currier, Holland, Drescher, & Foy, 2015). However, there have only been instrumentations geared more toward other constructs, but because of the recent influx of guerilla tactics and terrorism other instrumentations are needed for what today's service men and women face on the battlefield to better screen them (Currier et al., 2015). The instrument must be psychometrically sound (Currier et. al., 2015). "Clinicians and researchers historically have emphasized the consequences of life-threatening events in the etiology of posttraumatic stress disorder (PTSD) and related problems" (Currier, p. 81, 2016). A morally injurious experience (MIE) is seen as "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p. 700). The MIQ-M consists of 20 items designed to include six categories of MIEs (Currier, 2016). These categories included "acts of betrayal (i.e. by peers, leadership, civilians, or self; 3 items), acts of disproportionate violence inflicted on others (5 items), incidents involving death or harm to civilians (4 items), violence within military ranks (2 items), inability to prevent death or suffering (2 items), and ethical dilemmas and/or moral conflicts (4 items)" (Currier, p. 82, 2016).

A study conducted by Currier et al. (2015) found that the “MIQ-M could provide valuable information about a fuller range of war-zone stressors that may guide the therapeutic process in important ways” (p. 60). The study found a link between MIEs and more traditional diagnoses, such as PTSD (Currier et al., 2015). A higher score increases the potential for other concerns to be present that are better characterized by a moral injury (intense shame, spiritual/existential concerns) (Currier et al., 2015). The authors of the Currier et al. (2015) study ultimately concluded that there was initial, psychometric evidence that the MIQ-M could be a useful instrument, but noted that the research in this area is in its infancy and more study is needed.

Adaptive Disclosure. Another intervention being utilized in the treatment of moral injury is Adaptive Disclosure (AD). “AD can be defined as “a manualized therapy developed specifically for active-duty service members” (Gray et al., 2012, p. 409). It is an eight-session intervention that takes into account unique aspects of the phenomenology of military service in war” (Maguen & Litz, 2016). AD is tailored toward individuals who are serving in the military to better respond to moral injury and traumatic loss that otherwise would not be met by conventional treatments (Gray et al., 2012).

AD is based on core assumptions (Gray et al., 2012). The first assumption is that treating active-duty troops should be done so to provide a foundation for recovery (Gray et al., 2012). The treatment is viewed as more of an introduction than it is a final destination (Gray et al., 2012). Second, an assumption was made that was premised on the idea that active-duty personnel is unfamiliar with admitting their experiences (Gray et al., 2012). Third, another assumption was made that service members “needed to increase their awareness and insight, and modify problematic beliefs about combat and operational traumas, losses, and moral injuries” (Gray et

al., 2012, p. 410). Finally, it was assumed that “repeated exposure to memories of traumatic loss, acts of moral transgression, or betrayal experiences without a strategic therapeutic frame for corrective and countervailing attributions and appraisals, and without fostering corrective, and especially forgiveness-promoting, experiences inside and outside therapy would be counterproductive at best and even potentially harmful” (Gray et al., 2012, p. 410).

A trial of AD was completed consisting of 44 active-duty Marines that were referred by the staff at Camp Pendleton mental health clinic (Gray et al., 2012). “At its core, AD is an experiential exposure-based approach” (Maguen, 2016). Maguen (2016) stated the following objectives:

- “Exposure is used to uncover core features of focal combat and operational trauma and as a means of articulating the meaning and implication of these events.
- If the focal combat event is fear and life-threat-based, exposure is the sole approach.
- If the focal trauma is loss-based, patients are also asked to have an imaginary emotionally evocative real-time dialogue with the lost person.
- For moral injury, patients are guided through a dialogue with a forgiving and compassionate moral authority about the transgression.”

Indications showed in the Gray et al. (2016) study that “complex combat and operational stress injuries can be effectively treated in garrison [home station]” (Gray et al., 2012, p. 413). The Marines that participated in the AD trial were, overall, satisfied with how AD worked for them (Gray et al., 2012). Additional indications showed that an early intervention had a higher

likelihood of more positive symptom improvement (Gray et al., 2012). There is a case to be made the preemptive interventions could see an even more positive impact.

Military Culture and Deployment Impact

There appears to be a lack of emphasis on the military culture and the effect it has on a service member's susceptibility to moral injury. Traditionally, the structure of the military has built in, negative ramifications for its service members. For example, combat can present moral and ethical challenges to service members and is an integral part of the service member's obligations (Gray et al., 2012). Combat, especially over the last 15 years, has been a mainstay in the modern warrior's life with no end in sight. It has been a perpetual stream of deployments too far off lands for extended periods of time. This sort of life, with multiple deployments, takes a toll on the mental health of veterans. Despite this toll, room for error for these military service members to carry out their duties remains small. Unfortunately, errors can and often do happen, and the ramifications need to be effectively dealt with in order to help those that protect our country.

The military is a value-based organization. For example, the Army has seven core values: Loyalty, Duty, Respect, Selfless Service, Honor, Integrity, and Personal Courage (LDRSHIP) (U.S. Army, 2016). Another example is the Marine Corps, which stresses honor, courage, and commitment (U.S. Marine Corps, 2017). The military, for all of its positive attributes, "may have little tolerance for weakness, whether physical, mental, or moral" (Nash, Silva, & Litz, p. 790, 2009). This type of atmosphere may prevent service members from seeking help with their wounds whether they are physical, mental, or moral. Once a service member has completed their obligation, then they must readjust back to the "real world." This world is likely to be foreign to them and connecting with people may be difficult.

The military is a unique subset of the U.S. population. For instance, the military has a younger population even though members are serving longer than ever before with the average career lasting approximately seven years (Clever, 2013). A younger force gives credence to the idea that younger service members do not come into the military with the requisite skillset to contend with personal conflict. As there is a younger population, it is not difficult to imagine that some adaptation needed to happen to an ever-changing military. In fact, “most service members who are exposed to potentially morally injurious events meet this challenge in early adulthood, which can be a critical time in psycho-spiritual development” (Harris et al., p. 258, 2015). To the credit of the military, additional programs to help work with service members were developed that are either required or voluntary, such as resiliency training (United States Army, 2014). Furthermore, service branches, like the Army, are now requiring their service members who are exiting active service to go through transition training. This training provides exiting service members with resources and information to help them succeed after the military.

The programs the military has developed, such as Master Resiliency Training, alluded to earlier, and ACE (Ask, Care, Escort), appear to be helping. However, the programs are recent occurrences having only recently been utilized a military context. More information is needed on these programs to evaluate their effectiveness. The military recognized that something had changed within their demographics and culture. Before the latest conflicts in Iraq and Afghanistan, military culture dictated that its members keep their problems to themselves. This problem was due in large part to the stigmatization of mental illness in the military. The military has significantly changed in recent years, but decades of custom and normative behavior is something that will not change overnight. It will take a lot of time and patience. However, with frequent deployments in high-stress situations, the transition can be difficult.

Deployments have become the norm for military personnel over the last 15 years. Millions of men and women in our armed forces have deployed to Iraq and Afghanistan (Negrusa, 2014). It is becoming difficult to imagine a time when the public has not been informed of some military operation that is happening thousands of miles away. The deleterious effects of these conflicts are well documented with PTSD noted as the signature diagnosis associated with service members returning from combat overseas. However, this diagnosis does not explain every symptom that a service member may present, post-deployment.

Military tactics, techniques, and procedures have changed in recent years. In previous conflicts, you could readily identify your enemy. Now, as with the conflicts in Iraq and Afghanistan, the enemy employs guerilla tactics, and this has led to excessive violence for some of our veterans (Litz et al., 2009). The impracticality of war, in and of itself, can be damaging to combat veterans, but the ambiguity associated with an unknown enemy housed within civilian populations becomes a constant stressor for the service member (Litz et al., 2009). This damage is something that they carry with them for quite some time; if not for the rest of their lives if left unchecked (Vargas, Hanson, Kraus, Drescher, & Foy, 2013).

Service members have also become more lethal. “[M]any believe that the increase is because of reflexive fire training, which is believed to have increased the number of kills in OIF such that 40%-65% of soldiers reported killing enemy combatants” (Jinkerson, 2016, p. 123). In fact, “[I]n the Vietnam and post-Vietnam engagements, firings have increased 77%-87%” (Jinkerson, 2016, p. 123). This kind of exposure also increases the likelihood of a service member suffering a moral injury. The experiences of the service members, much like the demographics of the military population, are varied, which makes it difficult for a single intervention to be significantly effective (Currier, Harris, Park, Usset, & Voecks, 2015).

Killing and Suicide

A study was conducted that examined suicidal ideation among 2,854 U.S. soldiers who served in support of Operation Iraqi Freedom (OIF) (Maguen et al., 2011). In this study, 2.8% of the sample reported suicidal ideation (Maguen et al., 2011). This study indicated that there appears to be suicidal thinking and an inclination to want to self-harm related to other mental health predictors (Maguen et al., 2011).

Predictors can come in many forms. For example, alcohol and depression are often publicly associated with suicidal ideation (Maguen et al., 2011). Several information outlets have reported the suicide epidemic in the military over the last few years. It seems, at times, you cannot go a day without reading about it in a news article or read something on social media highlighting the problem. Challenges on Facebook have garnered attention where people challenge others to do 22 push-ups per day for 22 days to bring more awareness to this serious problem. Since the advent of Operation Enduring Freedom (OEF) and OIF, suicide rates among service members have increased (Selby et al., 2010). To date, it has not been vetted why suicide rates have increased.

People who serve in the military come into contact with situations unfathomable to most of the rest of the citizenry. There are unconventional aspects of war (deployments) can further exacerbate this with service members encountering situations that are difficult to make final decisions, e.g. fire on non-combatants (Litz et al., 2009). Whether the experience has to do with being blown up in a military vehicle by an improvised explosive device (IED) on the side of the road, coming into contact with the aftermath of the battle and having to come face-to-face with casualties, losing friends and other comrades in the course of conducting operations, or having to fire on an adolescent because he or she refused to put down the weapon, the experiences often

clash with deeply held beliefs of what “right” and “just” looks like. There are several situations a service member can come into contact with and the examples provided are by no means exhaustive. In any situation, a veteran could be left to feel as though they are worthless (condemning themselves); they can become withdrawn from friends, family, and even the rest of their military unit; or they feel as though they are unforgiveable. This can lead to the veteran feeling like they have do not have any options and are helpless to do anything about it (Litz et al., 2009).

In general, killing is something that is looked down on in American society. Even some religions have definitive statements on the issue of killing. In the Bible, the Ten Commandants state, affirmatively, thou shalt not kill. We have severe punitive punishments afforded by our legal system, including the death penalty, for perpetrators of killing another person. It is no surprise then that when somebody kills another person that they have feelings of guilt or shame. It has the potential of violating everything that a person has come to believe. However, in the culture of the military, especially in combat situations, killing the enemy is expected and often praised when done within the confines of the rules of engagement. Nevertheless, general societal norms do not necessarily encompass military norms. In fact, they are often at odds with one another. Despite acceptance within the ranks of the military, veterans must take what he or she did back with them to their families and communities when they redeploy to home station. This transition could produce intense feelings of guilt, shame, low self-esteem, etc. when the veteran no longer has the immediate connection to the military culture. In effect, the veteran feels as though people outside of the military do not understand their pain. For most civilians, it seems rational to say that this belief is true. This is where the Veterans Administration comes into play for veterans.

Treatment

One of the most confounding questions to ask is how to treat a moral injury. There are several treatments that are in use, but they do not necessarily help treat moral injuries. For example, CPT, one of the most used treatments in the VA system, tends to devalue feelings of guilt and denies the factual basis of guilt (Finlay, 2015). CPT and other similar therapies are not getting the job done in some cases although they have great value in others, e.g. for PTSD. One thing that the VA has been looking at incorporating into treatment environments is Prolonged Exposure Therapy. This therapy provides an opportunity to the service member to deconstruct and then reconstruct negative and painful experiences (National Center for PTSD, 2016). Eventually, it provides for relief, but after re-living the trauma. It is about repetition and talking about the trauma, which helps you to gain more control because you learn that you do not need to be afraid. The service member should not be asked a series of yes or no questions as is often found in military questionnaires about mental health. On the contrary, open-ended questions are most appropriate when asking someone to discuss their trauma. It allows for the service member to think and reflect about their experiences with the goal of identifying and incorporating new insights. Ultimately, the goal is to get the person to stop avoiding the trauma and to deal with it. This has been used in the treatment of PTSD (National Center for PTSD, 2016). However, whether this will be effective in treating a moral injury is yet to be determined.

Treatment, in general, is a challenge for moral injuries. The first thing that must happen is recognition that it exists. The goal should be to reconcile what the veteran is feeling about the event that caused the injury and discuss moral implications going forward. Answer questions about who or what is the veteran's moral authority. It is not something to be undertaken alone. Veterans should have someone to help him or her along the way, someone who can be there for

them when situations become difficult. Most importantly, the veteran must understand that he or she is not 100% responsible for whatever it is that happened and that it is okay to forgive his or herself.

Methods

A systematic literature review is the preferred research method for this study. A systematic literature review is a method used to research, evaluate, and gather current literature on a given topic. Utilizing this method of research, a collection of the most current and applicable literature was collected helping this researcher assess how moral injury affects the mental health of veterans after they return home from overseas combat deployments. The research was amassed utilizing specific criteria and search parameters.

Moral injury is often paired with PTSD and therefore literature on PTSD was also sought out for this review. The term moral injury is a relatively new construct and has only fairly recently begun to receive attention from academia. The articles used for this research paper were critically analyzed to find common themes found in the larger collection of writings on the topic. One of the main considerations in the selection of articles was the quality of each article. When reviewing the articles used for this paper particular scrutiny was given to the references each author cited and whether other researchers cited the article itself.

Inclusion Criteria

A significant amount of the literature available on the subject of moral injury was written within the last five to ten years. This observation indicates that this construct is in its infancy. Systematic reviews enable a researcher to organize previous research efforts and identify any possible gaps. All primary articles utilized for this research paper mentioned or at least discussed the topic of moral injury. Supplemental research was also used to fill in gaps that moral injury

research did not address, i.e. family issues related to deployments. It became apparent after reading several articles that the topic of posttraumatic stress disorder should also be given consideration as a comparison since both conditions share a similar symptomology. No articles were considered for inclusion older than 2001. Additionally, non-empirical resources were utilized as a supplement to the included empirical research on moral injury. This supplemental information came from The Moral Injury Project located at Syracuse University, the Watson Institute at Brown University, and the Veterans Administration.

Empirically based articles that focused on other topic areas, such as PTSD or veteran families, were also considered and/or included. The standard for inclusion was premised on the idea that the article should provide contrast to moral injury or otherwise be viewed as a valuable resource by this researcher and from an authoritative organization or author. All empirical research and supplemental resources addressed the topic of moral injury in some form or were relevant to the idea of veteran challenges after they return from deployment. Research articles or resources that did not fit within the inclusion criteria excluded from consideration with only a few exceptions.

Search Strategy

Each article considered for inclusion was assessed and narrowed in three ways. First, a search was conducted on the St. Catherine University library page using the term “moral injury.” This elicited 359,167 possible results, which were sorted by relevance by the St. Catherine library search engine. Articles were initially screened by title and for any reference to the military, veterans, or other related terminology to be used later that would help inform the second phase of the search strategy. Further search efforts included specific database searches through Academic Search Premier, PsychInfo, socINDEX, and Social Work Abstracts after

identifying search terms in the first search effort. The search terms included: “moral injury”, “war”, “morality”, “killing”, “PTSD”, “Iraq”, “Afghanistan”, “Operation Iraqi Freedom (OIF)”, “Operation Enduring Freedom (OEF)”, “gulf”, “combat veteran”, “transgress”, “military”, and “spirituality”. The abstracts were then reviewed to determine whether the subject matter of the article appeared to be relevant to the research question. If after reading the abstract the article was determined to be relevant, it was printed off and added to a list with the following categories: Database, Article Title, Search Strategy, and Author(s).

After ten articles were selected for inclusion, a snowball sampling was conducted of the references of each of the ten articles. Several authors, such as Brett Litz and Jonathan Shay among others, began to emerge as primary authors of or contributors to several articles related to moral injury. Those articles were assessed for relevance, quality, and whether they contributed to answering the research question. Grey literature was also utilized and a search of Google Scholar identified three organizations that had relevant and reliable information. The organizations are Moral Injury Project located at Syracuse University, the Watson Institute at Brown University, and the Veterans Administration.

Data Analysis

Utilizing the databases Academic Search Premier, PsychInfo, socINDEX, and Social Work Abstracts, a search was conducted in each database using the search terms listed in the inclusion criteria section of the systematic literature review. All of the relevant articles and resources were reviewed for common themes and authors. Additionally, the findings, discussion, and/or results sections were assessed.

Results

The goal of this systematic literature review was to collect and organize specific information as it relates to the following question: “How does moral injury affect the mental health of veterans after they return home from overseas combat deployments?” A number of issues contribute to this problem, such as increased exposure to ambiguous situations, inadequate measurement tools, transgressive acts, and so on. The results showed that there is enough evidence to support the idea that morally injurious events, such as failures in leadership, elicit negative outcomes for veterans and require more effective and numerous treatment models to better serve veterans.

Exposure

The two most recent conflicts the United States military has been involved in are transpiring in Iraq and Afghanistan. At any given time, approximately 10-20% of the over two million service members who have served in Iraq and Afghanistan show signs of a mental health problem (Gray et al., 2012). A study completed by Hoge et al. (2004) looked at the prevalence of mental health problems among three Army combat infantry units and one Marine Corps infantry unit. Among the 1709 soldiers and Marines who returned from Iraq there was a higher likelihood to report combat related experiences when compared to their Afghanistan counterparts (Hoge et al., 2004). These combat related experiences lead to physical and emotional stressors (Brenner et al., 2015). As one service member explained in the Brenner et al. (2015) article,

“The things you can see yourself being capable of, whether you did not do it while you were over there, you never realize . . . you are that type of person until . . . you are deployed and you seen those things . . . Then you come back . . . now you see like, [w]ow, okay, I’m a little be more messed up than I thought.” (p. 281).

The way in which wars have been carried out today has drastically changed when compared years past. For Afghanistan and Iraq, there is no uniformed enemy combatant; rather, the enemy is able to blend in with the civilian population (Litz et al., 2009). This has resulted in more ambiguity in war. If a decision is made to kill another person because they are thought to be an enemy combatant, there is a good chance you may make a mistake and kill an innocent person. Coupled with ambiguity is increased lethality. For example, the number of kills in Iraq increased 40% to 65%. Thus, the probability of a service member suffering a moral injury has also increased exponentially.

Inadequacy of Treatment Models

Many of these mental health problems experienced by service members do not fit into the prescribed components of PTSD or some other mental health diagnosis. AD, MIQ-M, and MIES have been developed to assist veterans (Currier et al., 2015; Gray et al., 2012; Nash et al., 2013). As a fairly new construct, there appears to be little research material on moral injury to review and as a review of the reference list of this paper will show, there are relatively few authorities on the construct of moral injury. Most of the information available on this construct is either theoretical (e.g., Litz et al, 2009) or qualitative (e.g., Drescher et al., 2011) (Vargas et al., 2013). The research material that was available showed a distinction between the most common problems associated with deployments, such as PTSD and TBI. For example, PTSD is fear-based and requires a diagnosis. More specifically, it has a triggering event of an actual or threatened death or serious injury (Litz et al, 2009). “Moral injury is a dimensional problem – there is no threshold for the presence of moral injury; rather, at a given point in time, a veteran may have none, or mild to extreme manifestations” (Maguen, 2016, p. 3). Also, a transgression is not a required component for a PTSD diagnosis. In fact, PTSD does not adequately encapsulate moral

injury (anxiety, anger, guilt) (Maguen, 2016). Moral injuries can have several causes, such as transgressive acts, which can make it difficult to identify triggers. For example, anger and aggression are often related to transgressive acts; however, there is a lack of available data about existing anger and aggression before veterans deploy to confirm this relationship (Frankfurt, 2016). It is clear that there are several situations that can happen in combat that will make it more likely that an injury will occur, but treatment strategies remain a challenge.

Military Culture

One of the greatest problems plaguing the military is suicide. On average, people who serve in the military are more likely to commit suicide than their civilian counterparts. According to a Veterans Administration Report (2016), veterans made up 18 percent of the U.S. adult suicide-related deaths. To put this in perspective, approximately one percent of the population will ever make the decision to serve in the military. Suicidal ideation has been linked to moral injury as a behavioral manifestation, but to date the military and their civilian counterparts have not been able to curb this epidemic.

The military follows a set of values. For example, the Army stresses loyalty, duty, respect, selfless service, honor, integrity, and personal courage. Another example is the Marine Corps, which stresses honor, courage, and commitment (Marine Corps, 2017). Failure of these values after having them ingrained into a soldier's sense of self can create intense internal conflict. Service members begin to question themselves and start asking, "Why did I not help that person. How can I ever be considered honorable after having done what I did?" Although the military has made great strides in being a more inclusive and understanding organization, as evidenced as reintegration programs like Master Resiliency Training, there remains a stigma within the ranks (United States Army, 2014). The stigma has to do with showing weakness to

your peers and it is often not tolerated despite what you may hear in the news or press releases, which only perpetuates existing guilt or shame and, ultimately, can lead to isolation (Jinkerson, 2016).

Most often, service members join right out of high school with the typical career lasting about seven years (Clever, 2013). These service members are at a critical time in their psycho-spiritual development (Harris et al., 2015). At this juncture in their development, service members are likely away from home for the first time, are tasting their first experience of independence, and are making decisions independent of the parents. Deployments at this stage of development can negatively impact many veterans because they are more impressionable than older veterans. Coupled with significant change, younger service members become susceptible to problematic transitions.

Discussion

The available research revealed a dearth of information about moral injury when compared to other well-known problems associated with veterans, such as PTSD. However, there does appear to be an increased interest in the subject in recent years, but the theoretical and qualitative literature is what is most common (e.g. Litz et al., 2009; Drescher et al., 2011). The results show that several of the EBTs currently being used are not appropriate for service members who have a moral injury. Unfortunately, these EBTs are the most commonly used approaches when working with veterans at the Veterans Administration who have mental health issues. Researchers have begun to recognize that new assessment tools, such as the MIQ-M, and interventions, such as Adaptive Disclosure (AD), are necessary to meet the needs of those service members who have a demonstrated moral injury.

Adequate treatments for moral injury are few and far between. As previously mentioned, there does appear to be an interest in developing new interventions and measurement tools for moral injuries, but these are still only relatively new and require further analysis. One of the major obstacles to developing interventions and measurement tools is acceptance of moral injury as a construct. Not only is their stigma associated with moral injuries within the culture of the military, there are a number of other constructs/diagnoses that garner much of the attention as it pertains to the mental health of veterans. This implies there is a competition for funding in many cases, which may be a barrier to developing treatments.

Military culture is a significant consideration when trying to formulate best practices for veterans. Military life and civilian life are two entirely different sets modes of living. For people who decide to serve in the military, they do so at the risk of great peril. They also give up certain freedoms and fall under the control of their military chain of command. It is common for a sense of family to develop among military members, but once a military member is separated from their respective branch, that family connection is gone. No longer do they have a leader or fellow service member looking out for them 24/7. Now, they need to become more self-sufficient, but when moral injuries are apparent it can become a seemingly impossible problem to overcome. This is where the military has made great strides and better prepares service members, even with unseen injuries, for life outside of the military. However, more can still be done.

Implications

A consideration for the treatment of veterans who suffer from a moral injury is proper diagnosing. Something that is not well known amongst the general public, but is very well known in veteran circles is that PTSD, not moral injury, is a compensable disability. More

specifically, if someone is suffering from a moral injury they cannot get VA compensation. In contrast, PTSD is compensable and has a fairly low threshold for provability. In order for a veteran to make a VA compensation claim for PTSD, all that is required is a veteran's lay statement to establish an occurrence as outlined in 38 CFR 3.304(f)(3). In other words, there is a clear and convincing legal standard required to prove that it is not service-connected, which is not easy to overcome.

The veteran population often finds themselves underemployed or not employed at all once they leave military service. It is possible that moral injury is underreported in the sense that veterans may present symptoms that fall in line more with PTSD than what they really have, which is a moral injury. Medical professionals may be more apt to diagnose PTSD because it is considered a mental disorder whereas moral injury is not. Moral injury, on the other hand, is dimensional, which could also lead to underreporting.

For social workers, who are in the trenches of combatting moral injury, what is it that must be considered when working with veterans who have a moral injury? Moral injury is an individual crisis in the sense that the same event affects people differently. It would be intellectually disingenuous to think otherwise. As social workers, a conversation needs to happen about moral injury. Raising awareness about moral injury will foster an environment that encourages change; however, caution must be taken to reduce the likelihood of further stigmatization. The empirically based treatments do not necessarily work when trying to treat for moral injury, which is confounding for mental health practitioners who are forced to utilize empirically based treatments. More research is needed to better identify distinctions between PTSD and moral injury.

Although the focus of this research paper has been on how moral injuries affect the veteran population, there are other populations that can be affected by a moral injury. For example, with regard to domestic violence, it is not difficult to imagine how a child might suffer from a moral injury after witnessing acts of domestic violence against a parent or suffering from one themselves. Another example is someone being assaulted on the street with witnesses standing nearby who do nothing to help. There is strong messaging in our society that tells us to help people who are in need. In this situation, not helping the person being assaulted could induce feelings of shame, low self-worth, and failure. This could lead to a moral injury. It is incumbent upon the profession of social work to recognize applications of this relatively new construct toward other populations that they serve. Much like with PTSD, moral injury is not just a problem associated with veterans.

Symptoms of moral injuries often do not present right away. It is a problem that eats at the person's soul. Initial assessments for veterans who return from deployments are decidedly needed; however, follow-ups are also needed. PTSD has a tendency to develop acutely whereas moral injury is more of a "slow burn." For the social work profession, this should be a part of their practice when working with those people whom they suspect may have encountered such an injury. The problem with moral injuries is that they are subjective and individually affective, which can make it difficult to assess. A thorough collection of background information is needed of the individual service member, e.g. where they were stationed, did they encounter combat situations, etc. Veterans, especially older veterans, have a tendency to "suck it up" and not discuss what is on their minds. Moral injuries in the military, because they are a new concept, are not likely to be received well by the veteran community. Like with PTSD, it will take time to

gain acceptance, so it will be necessary for the social work profession to be cognizant of this and to act accordingly.

Another consideration for the social work profession and the military services is preparation of service members before they deploy. Again, there is very little information regarding what is done to prepare veterans before they deploy to forward combat zones. The military has developed resiliency-based programs, such as the Army's Comprehensive Soldier and Family Fitness regulation (U.S. Army, 2014). However, these programs do not prepare a service member for what they could potentially see while deployed. The military should incorporate more preventative measures to better prepare service members for what they will likely see. They do a very good job in preparing service members for cultural differences as well as tactics, techniques, and procedures, but this is not enough. Social workers and other mental health professionals should be a part of the pre-mobilization process for service members, which would entail the formation of a new curriculum.

Future Research

Moral injury, as a construct, is meant to help veterans who are having problems reintegrating after serving their country (Frankfurt, 2016). One major shortcoming is theoretical development of treatment strategies. Organizations, like the Veterans Administration, have started to acknowledge moral injury, but they work off of EBTs and moral injury treatments that fit their criteria are limited.

More time and energy should be devoted to find alternative interventions for moral injury. However, before that can be done, additional instruments are needed to assess for a moral injury. Again, like with treatment strategies, there are few assessment instruments available for moral injury. The strategies of Adaptive Disclosure and MIQ-M are promising, but more options

are necessary. Co-morbidity of moral injuries and other mental health issues should also be considered. For example, service members who have a TBI most likely encountered a situation in which a moral injury likely could occur. Exploring treatment and assessment tools that take into account additional injuries occurring at the same time should be considered as areas of opportunity for future research.

Limitations

While this systematic literature review looked at all of the relevant authorities associated with answering the research question, there are some limitations. One major limitation found in this research was the lack of a uniform definition of what constitutes a moral injury. This makes it very difficult to pinpoint who has a moral injury and who does not. This issue should be further researched to reach a consensus on the causes of moral injury. As moral injury becomes a more mainstream construct, a standard cause (definition) will help it to gain more legitimacy.

Transgressive acts have been linked to moral injuries. However, the problem remains as to what acts are considered transgressive. The difficulty in pinpointing what constitutes a transgressive act is that people experience events or acts differently. One person might find killing another person to be the most morally bankrupt act imaginable. Another person might view it as a necessary evil given the set of circumstances they find themselves in. Essentially, it is a subjective experience. That is not to say that a set of common transgressive acts cannot be established; however, it would seem that it would have to be on a sliding scale and individually dependent when assessments are completed.

Another limitation are the assessment tools at the mental health practitioner's disposal. There are some very promising tools that are available; however, even more research is needed on these tools and more tools should be developed. It is persuasive, but far from clear, how

accurate moral injuries are being detected. This makes it difficult for professionals to come to a conclusion that someone has a moral injury when in fact they do. This is where misdiagnoses can happen, which will be detrimental to the veteran because the real problem is not being addressed.

Overlapping symptoms with other diagnoses is another issue that should be looked at further. For example, PTSD shares several symptoms with moral injury. Anger, depression, insomnia, anxiety, nightmares and self-medication with alcohol tend to be symptoms that are common in both. The question remains how one differentiates between the two. Other practitioners have advocated that both moral injury and PTSD can exist at the same time within one person. More research is needed to determine how to best differentiate between the two regardless of whether they are comorbid.

A surprising area that does not have a lot of content are the acts of atrocities and killing (Litz et al., 2009). More attention should be given to the areas that have already been identified as contributing events that could cause a moral injury. Regarding killing and atrocities, the proverbial phrase “war is hell” comes to mind. Researchers should further look into killing and the atrocities that come along with war. Our military is an honorable organization, but that is not to say that it does not, on occasion, perpetuate atrocities whether intended or unintended. Killing, on its face, is a part of war, so it is surprising that more in depth information is not a part of the literature as it pertains to moral injury.

Conclusion

There have been a host of names associated with veterans’ reactions to war, e.g. Soldier’s Heart, Shell Shock, Battle Fatigue, and most recently Post Traumatic Stress Disorder. Trauma in veterans is not a new consideration, but it is something that mental health practitioners have struggled to treat for several years. These are after effects of war, as well as unintended

consequences. Moral injury, as a construct, is in its infancy. There is not enough information or tools available to mental health practitioners to help fight this insidious problem. Veterans, at one point in their life, decided to give themselves to something larger than themselves. They wanted to serve their country and the country owes it to them to help in any way it can when veterans' service has concluded. In order to reintegrate veterans back into communities, we must look at all possible problems associated with returning veterans and moral injury appears to be a construct that has legitimacy. It is my hope that other researchers will take up this important research and begin to further develop an understanding of what a moral injury is and how it can be treated.

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Table 1.**(Post-Traumatic Stress Disorder and Moral Injury)**

	PTSD	Moral Injury
DSM Diagnosis	Yes	No
Description	Psychological/Mental	Moral/Ethical/Social/Cultural
Causation	Threats (Real or Perceived)	Betrayal/Shame/Regret/Transition
Public Recognition	Yes	No
Treatment	Yes	Some/still developing
VA recognition	Yes	Not really
Anxiety	Yes	Yes
Anger	Yes	Yes
Self-harm	Yes	Yes
Social problems	Yes	Yes
Self-handicapping behaviors	Yes	Yes

Note. Information collected for this table was collected from Vargas et al. (2013); Litz et al. (2009); Drescher et al. (2011); Maguen & Litz (2016); Maguen et al. (2010); Gray et al. (2012); and Hoge et al. (2004).

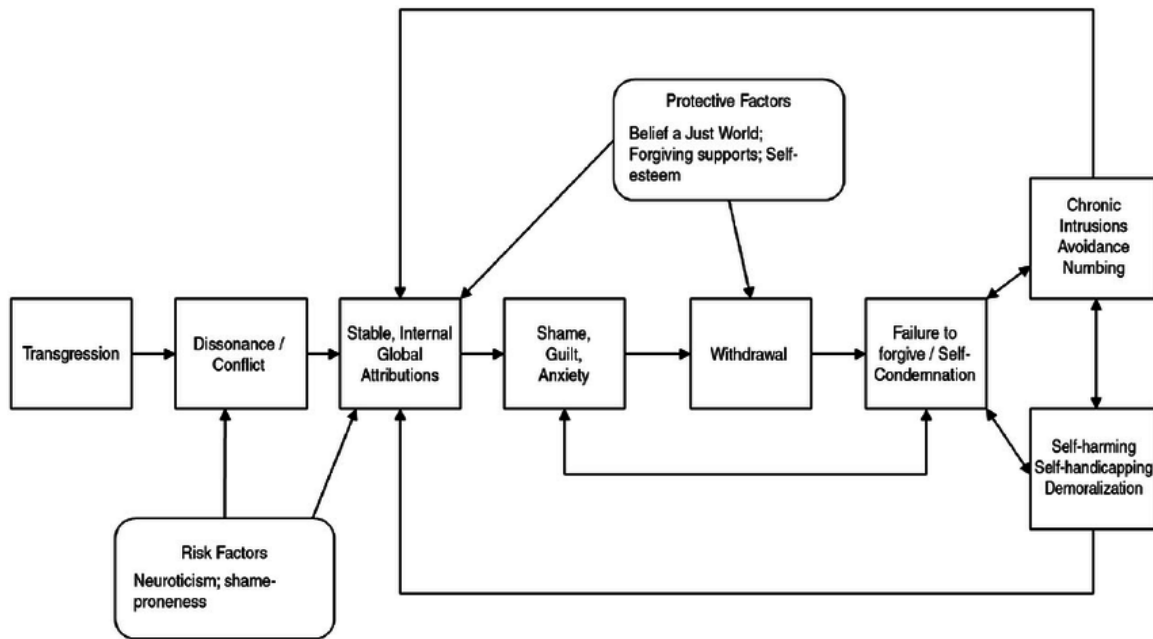


Figure 1. Working causal framework for moral injury (Litz et al., 2009).